

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then cause remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15497

CERTIFICATE OF DEATH

15497

| | | | | | | | | |
|--|----------------------------------|--|--|--|--|--|---|---------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Elk Mills ELKTON Life | | c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital of Cecil County | | | | | | |
| 3. NAME OF DECEASED (Type or print) Joseph Brooks Allen | | First Joseph | Middle Brooks | Last Allen | 4. DATE OF DEATH 11 14 1966 | Month 11 | Day 14 | Year 1966 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/21/83 | 9. AGE (in years last birthday) 82 yrs. | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONT. FIBRE | | 10b. KIND OF BUSINESS OR INDUSTRY LABOR | | 11. BIRTHPLACE (County & State, or foreign country) Chesapeake City, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Joseph Allen | | 14. MOTHER'S MAIDEN NAME Josephine | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Ella May Allen, Same | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Cardiac Failure | | DUE TO (b) Acute Coronary disease with infarction | | DUE TO (c) Cerebral Accident | | INTERVAL BETWEEN ONSET AND DEATH 1-Day | | |
| Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (the hospital) attended the deceased from 19/11/1966 to 11/14/1966 , and that death occurred at 8:PM , from the causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE James L. Johnson | | 22b. DATE SIGNED 11/15/66 | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D. | | 22d. ADDRESS 245 East High St., Elkton, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 11/17/66 | | 23c. NAME OF CEMETERY OR CREMATORIAL CHERRY HILL CEM. | | 23d. LOCATION (City, town or county) (State) CHERRY HILL, Md. | | |
| 24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME Donald M. Lee | | ADDRESS Elkton Md | | 25a. REC'D BY REGISTRAR NOV 17 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |
| | | | | | | | | |

72-61

72-61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | 15498 | | | |
|---|--|--|--|--|--|--|--|--|---|--|---------------------------------------|---|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | 15498 | | | |
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland | | | | | | b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | | c. LENGTH OF STAY IN 1b 2 years | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville | | | d. STREET ADDRESS Devine Nursing Home | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First Esther | | Middle E. | | Last Ansalsvish | | 4. DATE OF DEATH November 30, 1966 | | Month Day Year | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Cau. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Nov. 9, 1889 | | 9. AGE (In years last birthday) 77 yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | | 11. BIRTHPLACE (County & State, or foreign country) Penns. | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | |
| 13. FATHER'S NAME John T. Tweed | | | 14. MOTHER'S MAIDEN NAME Mary E. Wright | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | 16. SOCIAL SECURITY NO. None | | | 17. INFORMANT Mrs. Mary Leeflang, Perryville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. | | | Series of strokes | | | INTERVAL BETWEEN DEATH AND DISEASE 2 yrs | | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic cardiovascular disease | | | Unknown | | | |
| DUE TO (b) DUE TO (c) | | | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | |
| | 20c. TIME OF INJURY Month, Day, Year Hour a.m. While Not While p.m. at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 28</u> , 1966, to <u>Nov. 30</u> , 1966, that (I) (we) last saw the deceased alive on <u>Nov. 30</u> , 1966, and that death occurred at <u>Elkton</u> , M, from the causes and on the date stated above. | | | | | | | | | | | | | 22b. DATE SIGNED <u>Nov. 30, 1966</u> | | |
| 22a. SIGNATURE <u>Ralph Andrews, Jr</u> | | | | | | | | | | | | | 22b. DATE SIGNED <u>Nov. 30, 1966</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Ralph Andrews Jr</u> | | | | | | | | | | | | | 22d. ADDRESS <u>Elkton, Maryland</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/3/1966 | | 23c. NAME OF CEMETERY OR CREMATORIAL Spesucia Cemetery | | 23d. LOCATION (City, town & county) (State) Perryman, Harford, Md | | 25a. REC'D BY REGISTRAR Lee A. Patterson & Son, Perryville, Md. | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son</u> | | ADDRESS Lee A. Patterson & Son, Perryville, Md. | | DATE DEC 7 1966 | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|---------------------------|---|-----------------------------------|--|--|-----------------------------------|-------------------------|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 15499 | | | | | | 15499 | | | | | |
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton | | | c. LENGTH OF STAY IN 1b Life | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton 071 | | | d. STREET ADDRESS Walnut Lane | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Harry | Middle M. | Last Biddle | 4. DATE OF DEATH 11-21-1966 | Month 11 | Day 21 | Year 1966 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 23, 1874 | 9. AGE (In years last birthday) 92 yrs. | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS. Days 0 | 12. HOURS Hours 0 | 13. MIN. Min. 0 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY Ship Building | | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Jacob M. Biddle | | | | | | 14. MOTHER'S MAIDEN NAME Elizabeth E. Jones | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Spanish Amer. | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Mrs. Jacob T. Biddle, Elkton, Md. | | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 78 days | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 20-6-1966 to 20-24-1966, that (I) (we) last saw the deceased alive on 20-23-1966, and that death occurred at 731 M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Henry V. Davis | | | | | | 22b. DATE SIGNED 11/25/66 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Henry V. Davis | | | 22d. ADDRESS Chesapeake City, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF 11/26/66 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Elkton Cemetery | | | 23d. LOCATION (City, town or county) (State) Elkton, Md. | | |
| 24. FUNERAL DIRECTOR Felix E. Hicks | | | ADDRESS Hicks Home for Funerals, Elkton, Md. | | | 25a. REC'D BY REGISTRAR DATE DEC 7 1986 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15500

CERTIFICATE OF DEATH

15500

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| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge c. LENGTH OF STAY IN 1b 3 hrs. 25 m | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) n. Port Deposit 07/ | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Station Hospital, USNTC | | d. STREET ADDRESS R.D. #1 | |
| 3. NAME OF DECEASED (Type or print) (Child not named) | | First BUCK | Middle Last 4. DATE OF DEATH November 14 1966 |
| 5. SEX Female | | 6. COLOR OR RACE Caucasian | 7. MARRIED NEVER MARRIED WIDOWED DIVORCED |
| 8. DATE OF BIRTH Nov. 14, 1966 | | 9. AGE (In years last birthday) yrs. 3 25 | 10. IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----- | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 11. BIRTHPLACE (County & State, or foreign country) Cecil County, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown (None given) | | 14. MOTHER'S MAIDEN NAME Janet Marie BUCK | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ----- | | 16. SOCIAL SECURITY NO. ----- | |
| 17. INFORMANT Hospital Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7735 RESPIRATORY DISTRESS | | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) PREMATURITY | | | |
| DUE TO last. (c) PREMATURE LABOR | | | |
| INTERVAL BETWEEN ONSET AND DEATH 2 hrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) Bainbridge | | (County) Cecil | |
| (State) Md. | | | |
| 21. I certify that (b) (this hospital) attended the deceased from 14 Nov. 1966 , to 14 Nov. 1966 that (1) (we) last saw the deceased alive on 14 Nov. 1966 , and that death occurred at 5:13 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE D. Bremer | | A.M. 11/14/66 | |
| 22b. DATE SIGNED | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) WINDHAM BREMER LT MC USNR | | 22d. ADDRESS Station Hospital, USNTC, Bainbridge, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 14 November 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORIAL West Nottingham Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colora Cecil Md. | |
| 24. FUNERAL DIRECTOR LEE A. PATTERSON & SON, PERRYVILLE, MD. | | 25a. REC'D BY REGISTRAR DATE NOV 16 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Jones | |

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|--|--|--------------------------------------|--|---|--|--|--|--|--|--|--|---|--|-------------------------------|-------|--|--|
| 1. PLACE OF DEATH a. COUNTY Cecil | | | | MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland | | | | b. COUNTY Cecil | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton | | | | c. LENGTH OF STAY IN 1b 2 weeks | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North East | | | | 07/ | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital | | | | | | | | d. STREET ADDRESS 6 Beech St. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First GETTA | | Middle ANN | | Last CAMERON | | 4. DATE OF DEATH NOVEMBER 17 1966 | | Month November | | Day 17 | | Year 1966 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 25, 1895 | | 9. AGE (In years last birthday) 71 yrs. | | 10. IF UNDER 1 YEAR Months | | 11. IF UNDER 24 HRS. Days | | 12. IF UNDER 24 HRS. Hours | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | | | 11. BIRTHPLACE (County & State, or foreign country) Cecil Co. Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Joseph H. DeMonde | | | | 14. MOTHER'S MAIDEN NAME Suzanne M. Hamilton | | | | Address R.D. 2 North East, Md. | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. None | | | | 17. INFORMANT Omar H. Cameron | | INTERVAL BETWEEN ONSET AND DEATH 48 hours | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c) DUE TO Diabetic Acidosis DUE TO Diabetes Mellitus | | | | | | | | | | | | 5 years | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Atherosclerosis; Ischemia of Labyrinth, Left. Nephrosclerosis; Hiatus Hernia | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter Nature of Injury in Part I or Part II of Item 18.) | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. — 19 p.m. — | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1947</u> to <u>17 Nov 1966</u> , that (I) (we) last saw the deceased alive on <u>17 Nov 1966</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above. | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE Klaus H. Huebner | | | | | | | | 22b. DATE SIGNED 11/17/66 | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER M.D. | | | | 22d. ADDRESS NORTH EAST, Md. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/20/66 | | 23c. NAME OF CEMETERY OR CREMATORIAL North East Methodist | | 23d. LOCATION (City, town or county) North East Cecil Co. Md. | | (State) | | | | | | | | | |
| 24. FUNERAL DIRECTOR Grant Funeral Home | | ADDRESS Box 22 North East, Md. | | 25a. REC'D. BY REGISTRAR NOV 21 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | |
| B2 | | | | | | | | DATE | | | | | | | | | |
| VR A15 (4) 20M 1/65 | | | | | | | | | | | | | | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15502 **15502**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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| <p>1. PLACE OF DEATH a. COUNTY Cecil MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton.</p> <p>c. LENGTH OF STAY IN 1b Union Hospital.</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</p> | | <p>2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil.</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton.</p> <p>d. STREET ADDRESS</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | |
| <p>3. NAME OF DECEASED (Type or print) MARTHA ELIZABETH CANNAN</p> <p>4. DATE OF DEATH November 17, 1966</p> <p>5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH October, 12, 1875 9. AGE (In years last birthday) 91 yrs. 10. IF UNDER 1 YEAR Months Days Hours Min.</p> | | <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework</p> <p>10b. KIND OF BUSINESS OR INDUSTRY Own Home</p> <p>11. BIRTHPLACE (County & State, or foreign country) Md.</p> <p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p> | |
| <p>13. FATHER'S NAME James Albert Cannan</p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.</p> | | <p>16. SOCIAL SECURITY NO. 17. INFORMANT Joseph Short, Address Cecilton, Md. 21913</p> <p>14. MOTHER'S MAIDEN NAME Hester Ann Blackway.</p> | |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia</p> <p>491X DUE TO Conditions, if any, which gave rise to immediate (b) cause (a), stating the underlying cause last. (c)</p> | | <p>INTERVAL BETWEEN ONSET AND DEATH 6 days</p> | |
| <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Atraumatic fracture of right hip (pathologic due to osteoporosis</p> | | <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | |
| <p>20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 While <input type="checkbox"/> Not While <input type="checkbox"/> p.m. at work <input type="checkbox"/> at work <input type="checkbox"/></p> | | <p>20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)</p> | |
| <p>21. I certify that (I) (this hospital) attended the deceased from 5 Nov, 1966, to 17 Nov, 1966 that (I) (we) last saw the deceased alive on 17 Nov, 1966, and that death occurred at 11:50 AM causes and on the date stated above.</p> | | <p>22a. SIGNATURE Wallace O. Enshain 22b. DATE SIGNED 18 Nov 66</p> | |
| <p>22c. PHYSICIAN'S NAME (Type) Wallace O. Enshain, M.D.</p> | | <p>M.D. ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Cecilton, Md.</p> | |
| <p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Nov. 19, 1966 23c. NAME OF CEMETERY OR CREMATORIUM Cecilton Cemetery.</p> | | <p>23d. LOCATION (City, town or county) (State) Cecilton, Cecil Co; Md.</p> | |
| <p>24. FUNERAL DIRECTOR Edward Fellows.</p> | | <p>ADDRESS Millington, Md. 21651 25a. REC'D BY REGISTRAR NOV 21 1966 25b. REGISTRAR'S SIGNATURE Charles Judge</p> | |

200

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

M

15503

CERTIFICATE OF DEATH

Reg. Dist. No.

15503

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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|---|--|---|---|--|--|---|-------------------------------|------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Cecil | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Calvert | | c. LENGTH OF STAY IN 1b 3 Months | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Penns. | | b. COUNTY Chester | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Manor Nursing Home | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Lincoln University R.D.1 | | d. STREET ADDRESS 75-3 | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Mrs Anna May | | First | Middle | Last | 4. DATE OF DEATH November 23, | Month | Day | Year | |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 23, 1869 | | 9. AGE (In years at birthday) 97 yrs. | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Housework | | 10b. KIND OF BUSINESS OR INDUSTRY own Home | | 11. BIRTHPLACE (State or foreign country) Titusville, Penna. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Julius Lovell | | 14. MOTHER'S MAIDEN NAME Elizabeth Dowderr | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT E. Harvey Chase-Lincoln University #1 Pa. | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO | | Cardiac decompensation | | INTERVAL BETWEEN ONSET AND DEATH 5 days | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) diabetes mellitus | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M., from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) | | | DATE SIGNED | | | | |
| ACTUAL SIGNATURE Neil R Taylor M.D. | | Rising Sun, Md | | | 11-24-66 | | | | |
| PHYSICIAN'S NAME (Type) Neil R Taylor M.D. | | Rising Sun, Md | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/25/1966 | | 22c. NAME OF CEMETERY OR CREMATORIUM Union Cemetery | | 22d. LOCATION (City, town, or county) (State) Union Lancaster Co. Pa. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE E. Mullon | | ADDRESS Rising Sun, Md. | | 24b. REC'D BY REGISTRAR Nov. 28 1966 | | 24c. REGISTRAR'S SIGNATURE Charles Judge | | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

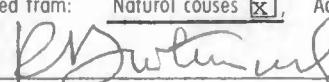
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15504

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15504

| | | | |
|--|---------------------------|--|--|
| 1. PLACE OF DEATH O. COUNTY Cecil Maryland | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) O. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit | | c. LENGTH OF STAY IN lb Since 1940 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 23 Race Street | | e. STREET ADDRESS 23 Race Street | |
| 3. NAME OF DECEASED (Type or print) CHARLES | | First SEYMORE | Middle CLARK |
| S. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> SEP. WIDOWED <input type="checkbox"/> | NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mess Attendant | | 8. DATE OF BIRTH Nov. 17, 1924 | |
| 10b. KIND OF BUSINESS OR INDUSTRY A. G. Ground | | 9. AGE (In years last birthday) 42 yrs. | |
| 11. BIRTHPLACE (State or foreign country) Philadelphia, Pa. | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13. FATHER'S NAME Seymore Clark | | 14. MOTHER'S MAIDEN NAME Elizabeth Carter | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 226-26-0975 | |
| 17. INFORMANT Mrs. Virginia H. Brown, Post-Kings, Md. | | Address 23 Race St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Fatty Metamorphosis of Liver | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | 22. DATE SIGNED 11/7/66 | |
| ACTUAL SIGNATURE  | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Rudiger Breitenecker | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov. 10, 1966 | 23c. NAME OF CEMETERY OR CREMATORIUM First Baptist Cemetery |
| 24. FUNERAL DIRECTOR Otelia J. Bullock, Harde de Gray, Md. | | 23d. LOCATION (City or Town) Cokesbury, Cecil, Md. | (County) (State) |
| ADDRESS 556 Lewis St. | | 25a. REC'D BY REGISTRAR NOV 9 1966 | 25b. REGISTRAR'S SIGNATURE Charles Judge |

40001

STANLEY H. LEE

40001

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15505

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15505

Item 8 Film 6283 12/12/66

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital | | d. STREET ADDRESS 071 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First ALVIN | Middle H. COXE | Last |
| 4. DATE OF DEATH | Month 11 | Day 30 | Year 1966 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 29, 1917 |
| 9. AGE (In years last birthday) 49 yrs. | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. Hours 0 |
| 13. FATHER'S NAME Samuel Heston Coxe. | | 14. MOTHER'S MAIDEN NAME Etta Dickerson. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. | | 16. SOCIAL SECURITY NO. 217-09-4880 | 17. INFORMANT (Cecelia) |
| | | Address Mrs. Catherine Coxe, Cecilton, Md. 21913 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA DUE TO 151X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 2 years | |
| 20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 111 |
| 20f. (City or town) Elkton | | (County) (State) Md. | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/30/66 to 11/30/66 , that (I) (we) last saw the deceased alive on 11/30/66 , and that death occurred at Elkton , M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John A. Fischer | | 22b. DATE SIGNED 12/1/66 | |
| 22c. PHYSICIAN'S NAME (Type) John A. Fischer | | 22d. ADDRESS ELKTON, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial. | | 23b. DATE THEREOF Dec. 3, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery. | | 23d. LOCATION (City, town or county) (State) Chestertown, Kent Co., Md. | |
| 24. FUNERAL DIRECTOR Edward Fellows. | | 25a. ADDRESS Millington, Md. 21651 | |
| | | 25b. REC'D BY REGISTRAR DEC 5 1966 | |
| | | 25c. REGISTRAR'S SIGNATURE Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15506

CERTIFICATE OF DEATH

15506

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Decil</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Decil</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i> | | c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North East</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Union Hospital</i> | | d. STREET ADDRESS <i>RG #1- Box 112</i> | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | e. DATE OF DEATH Month Day Year <i>Nov 18 1966</i> | |
| 3. NAME OF DECEASED (Type or print) | First <i>Marion</i> | Middle <i>G.</i> | Last <i>Denny</i> |
| 4. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>2/21/1898</i> |
| 9. AGE (In years last birthday) <i>68 yrs.</i> | 10. KIND OF BUSINESS OR INDUSTRY <i>Farm</i> | 11. BIRTHPLACE (County & State, or foreign country) <i>North Carolina</i> | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>Charlie Jerry</i> | 14. MOTHER'S MAIDEN NAME <i>Rebecca Osborne</i> | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | |
| 16. SOCIAL SECURITY NO. <i>252-12-64874</i> | 17. INFORMANT <i>Mrs Marion G. Jerry RG #1- Box 112</i> | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Cardiac arrest. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO Acute myocardial infarction last. (c) ASCVD. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (1) this hospital attended the deceased from <i>11-18</i> , 1966, to <i>11-18</i> , 1966, that (2) (we) last saw the deceased alive on <i>11-18</i> , 1966, and that death occurred at <i>4 p.m.</i> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>J. Barnhart</i> | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED <i>11-28-66</i> | |
| 22c. PHYSICIAN'S NAME (Type) <i>Barnhart</i> | 22d. ADDRESS <i>North East Cecil Co. Md.</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 23b. DATE THEREOF <i>11/21/1966</i> | 23c. NAME OF CEMETERY OR CREMATORIAL <i>Harford Memorial Gds.</i> | 23d. LOCATION (City or Town) (County) (State) <i>Bel Air Maryland</i> |
| 24. FUNERAL DIRECTOR <i>Walter Macaulay Jr. Tanning Funeral Home Inc.</i> | 25a. REC'D BY REGISTRAR ADDRESS <i>Chesapeake</i> | 25b. REGISTRAR'S SIGNATURE DATE DEC 2 1966 <i>Charles Judge</i> | |

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 15507

15507

| | | | | | | | |
|--|--------------------------|--|----------------------------------|---|--------------------------------|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Cecil | | MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Elkton | | STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkton | | COUNTY Cecil (If rural give location) Barksdale Road R.D. #4 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital | | | | STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or Print) Leona A. Dever | | | | 4. DATE OF DEATH Nov. 19, 1966 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH May 19, 1892 | 9. AGE last birthday 74 yrs. | IF UNDER 1 YEAR Months Deys | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Adv. Dept. DuPont | | | | 11. BIRTHPLACE (State or foreign country) Delaware | | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME William Crothers | | | |
| 14. MOTHER'S MAIDEN NAME Leona Lister | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT & ADDRESS Mr. William T. Dever (Same) | | | |
| 18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) ACUTE ANTERIOR MYOCARDIAL INFARCTION 12 hours ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. MILD ADULT DIABETES MELLITUS | | | | | | | |
| 19e. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| 21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. PLACE (Home, farm, livery, OF INJURY street, office bldg., etc.) 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> M. <input type="checkbox"/> | | | |
| 21f. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I hereby certify that I attended the deceased from Sept. 19, 1965, to 19 Nov., 1966, that I last saw the deceased alive on 19 Nov., 1966, and that death occurred at 8:05 P.M. from the causes and on the date stated above. SIGNATURE Robert J. Gray DATE SIGNED 11/23/66 | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 11/23/66 | | NAME OF CEMETERY OR CREMATORIAL Lawncroft Cemetery | | LOCATION (City, town, or county) Linwood, Pennsylvania | |
| 24. REC'D BY REGISTRAR DATE NOV 29 1966 | | REGISTRAR'S SIGNATURE Charles Judge | | 25. FUNERAL DIRECTOR'S SIGNATURE Albert J. McCrory, Jr. | | ADDRESS Wilmington, Del. 2700 Wash. St. | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15508

CERTIFICATE OF DEATH

15508

| | | | | | |
|--|-----------------------------------|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Cecil | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE District of Columbia | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. LENGTH OF STAY IN lb 59 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | | d. STREET ADDRESS 3125 Mt. Pleasant St., N.W. | | |
| 3. NAME OF DECEASED (Type or print) PETER | | First EDWARD | Middle DURST | 4. DATE OF DEATH November 17 | Month Year 1966 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED K NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 5-27-00 | 9. AGE (In years last birthday) 66 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe salesman | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) Shamokin, Penna. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Michael Durst (D) | | | 14. MOTHER'S MAIDEN NAME Marie E. (?) (D) | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 362-09-6515 | | 17. INFORMANT Address VA Hospital Records, Perry Point, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral | | | INTERVAL BETWEEN ONSET AND DEATH 1-2 weeks | | |
| DUE TO (b) Bronchogenic carcinoma of left lung | | | 1-2 years | | |
| DUE TO (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that (A) (this hospital) attended the deceased from Sept. 19 , 19 66 , to Nov. 17 , 19 66 , that death was not sudden and that death occurred at 9:15 am, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <i>J. R. Garcia, M.D.</i> | | | 22b. DATE SIGNED 11-17-66 | | |
| 22c. PHYSICIAN'S NAME (Type) J. R. GARCIA, M.D. | | 22d. ADDRESS VAH, Perry Point, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal - Burial | | 23b. DATE THEREOF 11/22/66 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | |
| 24. FUNERAL DIRECTOR W. W. Chambers Funeral Home, Washington, DC | | | 23d. LOCATION (City or Town) (County) (State) Arlington, Va. | | |
| ADDRESS | | | 25a. REC'D BY REGISTRAR DATE NOV 22 1966 | | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | |

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15509

CERTIFICATE OF DEATH

15509

| | | | | | | | | | |
|--|--|---|------------------------------------|---|---|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>CECIL</i> | MARYLAND | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>DEL.</i> | b. COUNTY <i>NEW CASTLE</i> | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ELKTON</i> | c. LENGTH OF STAY IN 1b <i>1 DAY</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>NEWARK</i> | 46-3 | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>UNION HOSPITAL</i> | d. STREET ADDRESS <i>74 E. PARK PLACE</i> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <i>CAROLEGENE</i> | First <i>Carol</i> | Middle <i>GENE</i> | Last <i>Ferguson</i> | 4. DATE OF DEATH Month <i>November</i> | Day <i>13</i> | Year <i>1966</i> | | | |
| 5. SEX <i>F</i> | 6. COLOR DR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>12/1/36</i> | 9. AGE (in years last birthday) <i>29 yrs.</i> | 10. IF UNDER 1 YEAR Months <i>0</i> | 11. IF UNDER 24 HRS Days <i>0</i> | 12. IF UNDER 24 HRS Hours <i>0</i> | 13. IF UNDER 24 HRS Min. <i>0</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i> | | 11. BIRTHPLACE (County & State, or foreign country) <i>BALTIMORE CITY</i> | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | |
| 13. FATHER'S NAME <i>WILLIAM H. MILLER</i> | | 14. MOTHER'S MAIDEN NAME <i>CAROLYN GULOTT</i> | | Address | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | | 17. INFORMANT <i>JAMES A. FERGUSON</i> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardopathy</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4222</i> | | DUE TO (b) <i></i> | | DUE TO (c) <i></i> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus with acidosis. Pulmonary abscess</i> | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) <i></i> | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i> | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>3 Nov</i> , 19 <i>66</i> , to <i>3 Nov</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>3 Nov</i> 19 <i>66</i> , and that death occurred at <i>12:15 PM</i> , from the causes and on the date stated above. | | | | | | | | | 22b. DATE SIGNED <i>5 Nov 66</i> |
| 22a. SIGNATURE <i>Wallace Obenshain</i> | | 22b. ADDRESS <i>Cecilton, Md.</i> | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <i>Wallace Obenshain, M.D.</i> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 23b. DATE THEREOF <i>11/17/66</i> | | 23c. NAME OF CEMETERY OR CREMATORIUM <i>OAK LAWN</i> | | 23d. LOCATION (City, town or county) (State) <i>BALTO MD</i> | | | |
| 24. FUNERAL DIRECTOR <i>PIPPIN FUNERAL HOME</i> | | ADDRESS <i>Elkton Md.</i> | | 25a. REC'D BY REGISTRAR <i>NOV 9 1966</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |
| VR A15 (4) 20M 1/65 | | | | | | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15510

CERTIFICATE OF DEATH

15510

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

| | | | | | | |
|---|---|--|--|---|--|---------------------|
| 1. PLACE OF DEATH a. COUNTY <i>CECIL</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ELKTON</i> | | c. LENGTH OF STAY IN 1b <i>1 HR.</i> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>UNION HOSPITAL</i> | | e. STREET ADDRESS <i>PLUM POINT</i> | | | | |
| 3. NAME OF DECEASED (Type or print) <i>John FLETCHER Ford</i> | | First <i>John</i> | Middle <i>FLETCHER</i> | | | |
| 4. DATE OF DEATH <i>11 23 1966</i> | Month <i>11</i> | Day <i>23</i> | Year <i>1966</i> | | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED | 8. DATE OF BIRTH <i>11/24/03</i> | | | |
| 9. AGE (In years last birthday) <i>62 yrs.</i> | 10. IF UNDER 1 YEAR <i>Months</i> | 11. IF UNDER 24 HRS. <i>Days</i> | 12. IF UNDER 24 HRS. <i>Hours</i> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i> | 10b. KIND OF BUSINESS OR INDUSTRY <i>—</i> | 11. BIRTHPLACE (County & State, or foreign country) <i>NORTH EAST, MD</i> | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>JOSEPH FORD</i> | 14. MOTHER'S MAIDEN NAME <i>NO. INFO.</i> | Address <i>108 HILLTOP, RD</i> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | 16. SOCIAL SECURITY NO. <i>109-12-4488</i> | 17. INFORMANT <i>EDWIN E. FORD</i> | INTERVAL BETWEEN ONSET AND DEATH <i>1-Day</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.2</i> | | | 2-Weeks | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>—</i> | | | 1-Year | | | |
| DUE TO (b) <i>Pulmonary Edema</i> | | | | | | |
| DUE TO (c) <i>Myocarditis, Asthma</i> | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | | | | 19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>+</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) <i>—</i> | (County) <i>—</i> | (State) <i>—</i> |
| 21. I certify that (I) (the deceased) attended the deceased from <i>11/22/66</i> to <i>11/23/66</i> that (I) (we) last saw the deceased alive on <i>11/23/66</i> and that death occurred at <i>8 PM</i> , from causes and on the date stated above. | | | | | | |
| 22a. SIGNATURE <i>James L. Johnson</i> | | 22b. DATE SIGNED <i>11/25/66</i> | | | | |
| 22c. PHYSICIAN'S NAME (Type) <i>James L. Johnson M.D.</i> | | 22d. ADDRESS <i>245 East High St., Elkton, Maryland</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 23b. DATE THEREOF <i>11/26/66</i> | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>NORTH EAST</i> | 23d. LOCATION (City or Town) <i>NORTH EAST MD. CECIL</i> | | |
| 24. FUNERAL DIRECTOR <i>PIPPIN FUNERAL HOME</i> | | 25a. REC'D BY REGISTRAR <i>Charles Judge</i> | | | | |
| | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15511

CERTIFICATE OF DEATH

15511

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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|--|-------------------------------|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Cecil | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton | | b. COUNTY Cecil | | |
| c. LENGTH OF STAY IN 1b 1 wk | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Childs 071 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital of Cecil County | | d. STREET ADDRESS | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | First Frances | Middle B. | Last Gallaher | |
| 4. DATE OF DEATH November 28 1966 | Month | Day | Year | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 9, 1907 | |
| 9. AGE (in years last birthday) 59 yrs. | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days | 12. IF UNDER 24 HRS. Hours | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmaster | | 11. BIRTHPLACE (County & State, or foreign country) U. S. Government Illinois | | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | |
| 13. FATHER'S NAME James H. Biggar | | 14. MOTHER'S MAIDEN NAME Sally Williams | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT Mr. A. Harlan Gallaher, Elkton, Md. | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | INTERVAL BETWEEN ONSET AND DEATH Unknown | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Nov. 25, 1966, to Nov. 28, 1966, that (I) (we) last saw the deceased alive on Nov. 28 1966, and that death occurred at 11:21 A.M. from the causes and on the date stated above. | | 22b. DATE SIGNED 12/1/66 | | |
| 22a. SIGNATURE S. Ralph Andrews, Jr. | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | |
| 22c. PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, Jr. MD | | 22d. ADDRESS Elkton, Maryland | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov 30 1966 | | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Leeds Cemetery |
| 24. FUNERAL DIRECTOR Ralph E. Hicks | | ADDRESS Hicks Home for Funerals, Elkton, Maryland | | 25a. REC'D BY REGISTRAR DATE DEC 7 1966 |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15512

CERTIFICATE OF DEATH

15512

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East 071 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hsp. | | d. STREET ADDRESS R.F.D. # 1 | |
| 3. NAME OF DECEASED (Type or print) Alexander Norris Gilbert | | First Last | 4. DATE OF DEATH Nov. 20 1966 Month Day Year |
| 5. SEX Male White | | 6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 8-29-1902 9. AGE (in years last birthday) 64 yrs. 10. KIND OF BUSINESS OR INDUSTRY Laborer Gen. Del-Mar Chem. Co. Virginia |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 11. BIRTHPLACE (County & State, or foreign country) Virginia | |
| 13. FATHER'S NAME Russell R. Gilbert | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 218-07-0974 17. INFORMANT Mrs. Albert Shoeman Rising Sun, Md. Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 163X | | INTERVAL BETWEEN ONSET AND DEATH BRAIN METASTASES | |
| Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. 163X | | DUE TO (b) CARCINOMA LEFT LUNG DUE TO (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) p.m. 19 While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1963, 1966, to 20 Nov, 1966, that (I) (we) last saw the deceased alive on 19 Nov, 1966, and that death occurred at 7 PM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Robert L. Gray | | 22b. DATE SIGNED 21 Nov 1966. | |
| 22c. PHYSICIAN'S NAME (Type) Robert L. Gray | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22d. ADDRESS ELKTON MEDICAL PARK ELEKTON |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11-23-66 | |
| 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Brookview Cem., | | 23d. LOCATION (City, town or county) (State) Rising Sun, Md. | |
| 24a. FUNERAL DIRECTOR John Allen | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge DATE NOV 23 1966 | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 23c, 23d Film G303 12/17/66 mn

15513

CERTIFICATE OF DEATH

15518

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania Chester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville | | c. LENGTH OF STAY IN 1b 1 yr, 9 mo | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital, Perry Point, Md. | | e. STREET ADDRESS Box 114 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Harry M. Grason | | First Harry | Middle M. |
| 4. DATE OF DEATH November 26 1966 | Month November | Day 26 | Year 1966 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED WIDOWED <input checked="" type="checkbox"/> | NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH 1-30-88 | | 9. AGE (In years lost birthday) 78 yrs. | IF UNDER 1 YEAR Months 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill hand | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) Chester, Pa. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Mortimer B. Grason (Deceased) | | 14. MOTHER'S MAIDEN NAME Hattie Jackson (Deceased) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 1 | | 16. SOCIAL SECURITY NO. 184-09-0136 | 17. INFORMANT Address VA Hospital records, Perry Point, Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia | | INTERVAL BETWEEN ONSET AND DEATH 7 days | |
| 491X DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) DUE TO stating the underlying cause lost. (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20. MEDICAL CERTIFICATION Arteriosclerosis. Osteomyelitis right tibia. Secondary anemia | | 21. I certify that (I) (this hospital) attended the deceased from Feb. 18, 1965 , to Nov. 26, 1966 , and performed xx and that death occurred at 7:55 P.M. , from causes and on the date stated above. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) VAH Perry Point, Md. |
| 20f. (City or town) (County) (State) | | 20g. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb. 18, 1965 , to Nov. 26, 1966 , and performed xx and that death occurred at 7:55 P.M. , from causes and on the date stated above. | | 22b. DATE SIGNED 11-27-66 | |
| 22c. SIGNATURE Alfred G. Gillis | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22d. ADDRESS VAH Perry Point, Md. |
| 23a. CEMETERY OR CREMATORIUM REMOVAL (Specify) Removal | | 23b. DATE THEREOF Nov. 30, 1966 | 23c. NAME OF CEMETERY OR CREMATORIUM Oxford |
| 23d. LOCATION (City or Town) Oxford (County) Penn. | | 23e. ADDRESS 10th & Chestnut Sts., Oxford, Pa. | |
| 24. FUNERAL DIRECTOR James Blawie, 86 Penn St. Oxford Pa | | 25a. ADDRESS 10th & Chestnut Sts., Oxford, Pa. | 25b. REGISTRAR'S SIGNATURE Charles Judge |
| 25c. DATE NOV 30 1966 | | 25d. DATE NOV 30 1966 | |

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

certificate be executed within 24 hours after death.

law requires that

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

15514

CERTIFICATE OF DEATH

15514

| | | | | | | | | | |
|--|----------------------------------|---|--|--|--|---|--------------------------------------|-------------------------------------|-----------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville | | c. LENGTH OF STAY IN lb 25 yrs, 7 mos., 5 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | d. STREET ADDRESS 2341 Loretta Avenue | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital, Perry Point, Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Oliver | | First | Middle | Last | 4. DATE OF DEATH Gross | Month November | Day 28 | Year 1966 | |
| S. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> | NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH 11/25/87 | 9. AGE (In years last birthday) 79 | IF UNDER 1 YEAR Months 79 | IF UNDER 24 HRS. Days 0 | Hours 0 | Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oysterman | | 10b. KIND OF BUSINESS OR INDUSTRY Oyster | | 11. BIRTHPLACE (County & State, or foreign country) Calvert County, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME John Frank Gross | | | | 14. MOTHER'S MAIDEN NAME Sidney Johnson | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I | | 16. SOCIAL SECURITY NO. 218-18-7863 | | 17. INFORMANT VA Hospital Records, Perry Point, Md. | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465X | | Pulmonary infarction, lower lobe, right lung INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { | | DUE TO (b) Massive pulmonary embolus, sudden | | | | | | | |
| | | DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA attended | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) John Goldgraben , attended the deceased from 4/23/1941 to 11/28/1966 , VA Hospital, Perry Point, Md. X and that death occurred at 11:10 pm from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE S. Goldgraben | | M.D. ATTENDING PHYS. <input type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 11-29-66 | |
| 22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D. | | 22d. ADDRESS VA Hospital, Perry Point, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE THEREOF 12-5, 66 | | 23c. NAME OF CEMETERY OR CREMATORIAL St. John C.Cem | | 23d. LOCATION (City or Town) Lusby | | (County) Calvert | (State) Md. |
| 24. FUNERAL DIRECTOR Pinkney Sewell | | ADDRESS Maryland | | 25a. REC'D BY REGISTRAR DEC 7 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

15515

CERTIFICATE OF DEATH

15515

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|----------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. LENGTH OF STAY IN 1b 1 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manassas | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | e. STREET ADDRESS 556 Centerville Road, Lot 83-3 | | 95 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) CHARLES WILLIAM HALL | | First | Middle | Lost | 4. DATE OF DEATH Month November Month 16 Day 1966 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED WIDOWED <input type="checkbox"/> | NEVER MARRIED DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-25-12 | 9. AGE (In years last birthday) 54 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Washington, DC | |
| 13. FATHER'S NAME Edward S. Hall (D) | | 14. MOTHER'S MAIDEN NAME Margie M. Purcell (L) | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 578-12-2104 | | 17. INFORMANT Address VA Hospital Records, Perry Point, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X | | Acute Pulmonary Edema | | INTERVAL BETWEEN ONSET AND DEATH 8-10 hrs | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause last. (b) DUE TO Bronchopneumonia, Bilateral | | | | Unknown | |
| (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) November 15, 1966 | (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from November 15, 1966 to November 16, 1966 , and that death occurred at 6:45 M. from causes and on the date stated above. pm | | | | | |
| 22a. SIGNATURE <i>Balbir Singh M.D.</i> | | M.D. ATTENDING PHYS. <input type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input checked="" type="checkbox"/> | 22b. DATE SIGNED 11-17-66 |
| 22c. PHYSICIAN'S NAME (Type) BALBIR SINGH, M.D. | | 22d. ADDRESS VA Hospital, Perry Point, Md. | | | |
| 23a. FUNERAL PREPARATION, REMOVAL (Specify) Removal | | 23b. DATE THEREOF 21 NOV. 66 | 23c. NAME OF CEMETERY OR CREMATORIAL Arlington National | 23d. LOCATION (City or Town) Arlington, Virginia | (County) (State) |
| 24. FUNERAL DIRECTOR <i>Arlington Funeral Home</i> by C. N. Craft | | ADDRESS 3901 N. Fairfax Dr. | 25a. REC'D BY REGISTRAR DATE NOV 21 1966 | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

direct

direct or indirect

direct

direct

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indirect via α and β pathways

via α pathway

via β pathway

indirect via β

via α pathway

via β pathway

(1) Direct or indirect

via α pathway

via β pathway

via β pathway

via α pathway

via β pathway

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Item 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and Item 3 within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15516

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15516

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit-rural | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Port Deposit | | d. STREET ADDRESS 36 Granite Ave. | |
| 3. NAME OF DECEASED (Type or print) FREEL Fred | | First Fred | Middle Hampton |
| 4. DATE OF DEATH 11 25 19 66 | Month Day Year | 5. AGE (In years last birthday) 52 yrs. | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | 8. DATE OF BIRTH 12/19/1913 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Town of P. D. | |
| 13. FATHER'S NAME Shade Hayes | | 14. MOTHER'S MAIDEN NAME Louie Jane Brooks | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 223-12-7427 | |
| 17. INFORMANT Mrs. Frances Hayes, Port Deposit, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 919.8 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) _____ (c) _____ | | | |
| DUE TO shot while hunting | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) shot while hunting | |
| 20c. TIME OF INJURY Month, Day, Year Hour xx 4:30 p.m. 11 25 19 66 | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg, etc.) woods |
| 20f. (City or town) Port Deposit | | (County) (State) Cecil Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | 22. DATE SIGNED 11/26/66 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/29/1966 | 23c. NAME OF CEMETERY OR CREMATORIAL Hopewell Cemetery |
| 24. FUNERAL DIRECTOR See O. Patterson, Jr. | | ADDRESS Perryville, Md. | 25a. REC'D BY REGISTRAR Charles Judge |
| | | DATE DEC 1 1966 | 25b. REGISTRAR'S SIGNATURE |

81221

81221

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or interment.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15517

15517

1. PLACE OF DEATH
a. COUNTY

Cecil

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Elkton

c. LENGTH OF STAY IN 1b

11 Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Union Hospital

3. NAME OF
DECEASED
(Type or print)

ETTA

A.

First

Middle

Last

4.

DATE

OF

DEATH

Month

Day

Year

HUNT

e. IS RESIDENCE
ON A FARM?

YES NO

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (in years
last birthday)

52 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

Female

White

WIDOWED

DIVORCED

May 4, 1914

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

School Teacher

10b. KIND OF BUSINESS OR INDUSTRY

Teaching

11. BIRTHPLACE (County & State, or foreign country)

Anderson County, S. C. USA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

J. M. Alexander

14. MOTHER'S MAIDEN NAME

Etta Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

262-38-4080

Mrs. Martha A. Riley, Seneca, S. C.

INTERVAL BETWEEN
ONSET AND DEATH

Unknown

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

5810

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Cirrhosis of the liver

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour e.m.

p.m.

19

20d. INJURY OCCURRED

While Not While

at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 11, 1966, to Nov. 23, 1966, that (I) (we) last
saw the deceased alive on Nov. 22, 1966, and that death occurred at 5:50 A.M. from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

Nov. 25, 1966 Mountain View Cem. Seneca, South Carolina

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

23d. LOCATION (City, town or county)

22b. DATE
SIGNED

11/23/66

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

PIPPIN FUNERAL HOME

ADDRESS

Elkton, Md.

25. REC'D BY REGISTRAR

NOV 25 1966

DATE

25b. REGISTRAR'S SIGNATURE

Charles Judge

number

and all of which

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infection, with the 3rd seen signs of

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15518

CERTIFICATE OF DEATH

15518

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u> | | c. LENGTH OF STAY IN 1b <u>2 yrs.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>16 Church St.</u> | | d. STREET ADDRESS <u>18 Church St.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>JESSE GEORGE HURT</u> | | First | Middle |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 23, 1906</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hospital Aid</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>V.A. Hospital</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>Hinton, W. Va.</u> |
| 13. FATHER'S NAME <u>Wash Hurt</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>WW 2 233-14-3966</u> | 17. INFORMANT <u>Mrs. Carol J. Hollenbaugh</u> Address <u>18 Church St. North East, Md.</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion with Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO last. (c) <u></u> | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> 19 p.m. <u>—</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/19</u> , 19 <u>66</u> , to <u>11/18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/8</u> 19 <u>66</u> , and that death occurred at <u>12:15 A.M.</u> from causes and on the date stated above. | | 22b. DATE SIGNED <u>11/8/66</u> | |
| 22a. SIGNATURE <u>Klaus H. Huebner</u> | | M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. ADDRESS <u>NORTH EAST, Md.</u> |
| 22c. PHYSICIAN'S NAME (Type) <u>KLAUS H. HUEBNER</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Union</u> <u>Cecil</u> <u>Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>11/11/66</u> | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Union Cemetery</u> |
| 24. FUNERAL DIRECTOR <u>Grant Funeral Home</u> | | 25a. REC'D BY REGISTRAR <u>Paul P. Crouch</u> ADDRESS <u>102-22 North East, Md.</u> DATE <u>NOV 10 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15519

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15519

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|--|------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Cecil</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i> | | c. LENGTH OF STAY IN 1b <i>1/2 hour</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Union Hospital</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Ned Keys</i> | | 4. DATE OF DEATH Month <i>11</i> | Month Year <i>21 1966</i> |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>5-27-27</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Mushroom Farm</i> | |
| 13. FATHER'S NAME <i>Lee Keys</i> | | 11. BIRTHPLACE (State or foreign country) <i>N.C.</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i> | | 14. MOTHER'S MAIDEN NAME <i>Ethel Oliver</i> | |
| 16. SOCIAL SECURITY NO. <i>155-20-6944</i> | | 17. INFORMANT Address <i>Mrs. Ida Keys, R.D.5, Elkton, Md.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last. (c) | | INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | 22. DATE SIGNED <i>11-21-66</i> | |
| ACTUAL SIGNATURE <i>John McByers</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. | |
| EXAMINER'S NAME (Type) <i>John McByers, M.D.</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Elkton, Md.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>11/25/66</i> | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Jones Cemetery</i> |
| 24. FUNERAL DIRECTOR <i>Joseph L. Hicks</i> | | 25a. REC'D BY REGISTRAR DATE <i>DEC 7 1966</i> | |
| Hicks Home for Funerals, Elkton, Md. | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

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FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15520

1. PLACE OF DEATH

a. COUNTY

CECIL

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

EARLEVILLE RURAL LIFE

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

MARYLAND

b. COUNTY

CECIL

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

EARLEVILLE RURAL 071

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

11 - 7 1966

5. SEX

6. COLOR OR RACE

FEMALE WHITE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

04 27- 1900

9. AGE (In years
last birthday)

66

yrs.

months

days

hours

min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEORGE W. COX

14. MOTHER'S MAIDEN NAME

ELLA V. HODSON

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or dates of service)

NO

16. SOCIAL SECURITY NO.

212-38-0391

17. INFORMANT

EDWARD FELLOWS CECILTON 40

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

ACTUAL SIGNATURE *Henry V. Davis*

EXAMINER'S NAME (Type)

HENRY V. DAVIS

ADDRESS

JOINTOWN CEMETERY

EARLEVILLE, CECIL Co. MD.

22b. DATE THEREOF

11/10/66

22c. NAME OF CEMETERY OR CREMATORI

JOINTOWN CEMETERY

EARLEVILLE, CECIL Co. MD.

22d. LOCATION (City, town, or county)

EARLEVILLE, CECIL Co. MD.

(State)

24a. REC'D BY REGISTRAR

NOV 10 1966

24b. REGISTRAR'S SIGNATURE

Charles Judge

DATE

11/10/66

DATE SIGNED

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15521

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15522

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Hartford</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i> | | c. LENGTH OF STAY IN 1b <i>D.O.A.</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Union Hospital</i> | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <i>Pearl</i> | | First <i>Marie</i> | Middle <i>McCallister</i> |
| 4. DATE OF DEATH <i>11 - 14 1966</i> | | Month <i>Nov.</i> | Day <i>14</i> |
| 5. SEX <i>F</i> | | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED |
| 8. DATE OF BIRTH <i>8-24-02</i> | | 9. AGE (In years last birthday) <i>64</i> | 10. IF UNDER 1 YEAR Months <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Canner Worker</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Canning</i> | 11. BIRTHPLACE (State or foreign country) <i>Pg.</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>William M. Schenck</i> | |
| 14. MOTHER'S MAIDEN NAME <i>Ada Garrine</i> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | |
| 16. SOCIAL SECURITY NO. <i>166-12-5214</i> | | 17. INFORMANT <i>Williams. McCallister, Cardiff, Md.</i> | Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>Immed.</i> | |
| 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> At work <input type="checkbox"/> of work <input type="checkbox"/> At work <input type="checkbox"/> | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>John McByers</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <i>John McByers, M.D.</i> | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | Address (Street, city, town, or county) <i>Elkton, MD.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 23b. DATE THEREOF <i>Nov. 17, 1966</i> | 23c. NAME OF CEMETERY OR CREMATORIAL <i>GUINSTON</i> |
| 23d. LOCATION (City or Town) (County) (State) | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR <i>John H. Hartman, DELTA, Pa.</i> | | 25a. REC'D BY REGISTRAR ADDRESS | 25b. REGISTRAR'S SIGNATURE DATE |
| | | NOV 17 1966 <i>Charles Judge</i> | |

88221

DATA FROM THE 1980 CENSUS

88221

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15522

CERTIFICATE OF DEATH

15523

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | |
|---|----------------------------------|---|---|---|--|---|-------|------|
| 1. PLACE OF DEATH a. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. | | b. COUNTY Cecil | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton Rural | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton. | | d. STREET ADDRESS | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | | First EDGAR | Middle C. | Last McCoy | 4. DATE OF DEATH November 27, 1966 | Month | Day | Year |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 8, 1897 | 9. AGE (In years last birthday) 69 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | Hours | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic Ret. | | 10b. KIND OF BUSINESS OR INDUSTRY Automobile | | 11. BIRTHPLACE (County & State, or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Wilmer W. McCoy | | 14. MOTHER'S MAIDEN NAME Cora Carter | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. | | 16. SOCIAL SECURITY NO. 217-03-1288 | | 17. INFORMANT Mrs. Susie B. McCoy, Cecilton, Md. 21913 | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO Conditions, if any, which gave rise to immediate (b) cause (a), stating the underlying cause last. (c) Pyelonephritis | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 2 mos | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral thrombosis secondary to Cerebral arteriosclerosis | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or Item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Cecilton, Md. | | (County) 21913 | (State) Md. | | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 1, 1962 , to 27 Nov, 1966 , that (I) (we) last saw the deceased alive on 27 Nov 1966 , and that death occurred at 6:30 PM from the causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE <i>Wallace Obenshain</i> | | 22b. DATE SIGNED 29 Nov 66 | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D. | | 22d. ADDRESS Cecilton, Md. 21913 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 1, 1966 | 23c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery. | 23d. LOCATION (City, town or county) Chesapeake City, Cecil Co., Md. | | (State) | | |
| 24. FUNERAL DIRECTOR Edward Fellows, | | ADDRESS Millington, Md. | | 25a. REC'D BY REGISTRAR DEC 2 1966 | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | DATE | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15523

CERTIFICATE OF DEATH

15524

| | | | | | | | |
|---|---------------------------|---|------------------------------|---|--------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware | | b. COUNTY N.C. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. LENGTH OF STAY IN 1b 1 hr. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Newark | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital | | d. STREET ADDRESS R.D. #2 Elkton, Md. | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First John | Middle B. | Last McDaniel | 4. DATE OF DEATH 11-22-66 | Month 11 | Day 22 | Year 1966 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-2-1901 | 9. AGE (In years last birthday) 65 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | IF UNDER 24 HRS. Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (County & State, or foreign country) New Castle, Dela. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George McDaniel | | 14. MOTHER'S MAIDEN NAME Margaret Eliz. Dillon | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 221-22-6498 | | 17. INFORMANT Josephine A. McDaniel | | Address Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 | | | | Myocardial Infarction | | | |
| Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) | | | | Hypertensive and Arteriosclerotic - Coronary artery disease. | | | |
| DUE TO (c) | | | | 3 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gout | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED White Not White at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug 1966, to Nov 22, 1966, that (I) (we) last saw the deceased alive on 11-21-1966, and that death occurred at 134 M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Williford Eppes | | | | 22b. DATE SIGNED 11-23-66 | | | |
| 22c. PHYSICIAN'S NAME (Type) Williford Eppes M.D. | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | |
| 22d. ADDRESS Medical Bldg. Main St, Newark, Dela. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11-25-66 | | 23c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery | | 23d. LOCATION (City, town or county) (State) Chesapeake City, Md. | |
| 24. FUNERAL DIRECTOR William J. Warwick | | ADDRESS Newark, Delaware | | 25a. REC'D BY REGISTRAR NOV 28 1956 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

10261

10261

1 M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15524

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15525

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY CECIL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DEL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL | | c. LENGTH OF STAY IN 1b — | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SASSAFRAS RIVER | | d. STREET ADDRESS 140 DEVONSHIRE Rd. | |
| 3. NAME OF DECEASED (Type or print) CHESTER | | First ALLEN MELLINGER JR | Middle — |
| 3. NAME OF DECEASED (Type or print) CHESTER | | Last ALLEN MELLINGER JR | 4. DATE OF DEATH NOVEMBER 4, 1966 |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED — |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DuPont Co | | 10b. KIND OF BUSINESS OR INDUSTRY EXG | |
| 13. FATHER'S NAME C. ALLEN MELLINGER SR | | 11. BIRTHPLACE (State or foreign country) DEL | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — | | 16. SOCIAL SECURITY NO. 222-10-6858 | |
| 17. INFORMANT W. S. LYNCH - WILM. DEL | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning | | INTERVAL BETWEEN ONSET AND DEATH Immed. | |
| 9248 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) None known | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell overboard during rough weather | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 130 p.m. 11-4-1966 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sassafras River |
| 20f. (City or town) Cecil | | (County) (State) MD | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | 22. DATE SIGNED 11-8-66 | |
| ACTUAL SIGNATURE Tillman D. Johnson | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. | |
| EXAMINER'S NAME (Type) Tillman D. Johnson | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 123 S. Sincerity Ave., Elizabethtown, PA | |
| 23a. BURIAL, CREMATION, REMOVED (Specify) BURIAL | | 23b. DATE THEREOF 11/10/66 | 23c. NAME OF CEMETERY OR CREMATORIAL GRACE LAWN |
| 24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME | | ADDRESS Elkton, Md | 23d. LOCATION (City or Town) (County) (State) WILM. N. CASTE DEL |
| 25a. REC'D BY REGISTRAR DATE NOV 14 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

3528

223

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15525

CERTIFICATE OF DEATH

15526

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

Cecil

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

North East

c. LENGTH OF STAY IN b.

1 1/2 Yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Pratt Nursing Home

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Month

Dey

Year

Mary

E.

Miller

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

Female

Cau.

WIDOWED DIVORCED

May 21, 1875

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Retired

Maryland

USA

13. FATHER'S NAME

Enoch K. Miller

14. MOTHER'S MAIDEN NAME

Fannie Jeffreys

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Emma E. Miller, Port Deposit, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

422.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Myocard. infar.

INTERVAL BETWEEN
ONSET AND DEATH

48 hrs

10 yrs

MEDICAL CERTIFICATION

2d. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

2d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.2d. INJURY OCCURRED
While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

19

21. I certify that (I) (this hospital) attended the deceased from Jan. 12, 1957, to 11-23, 1966, that (I) (we) last
saw the deceased alive on 11-27, 1966, and that death occurred at 5:00 P.M. from the causes and on the date stated above.

22. SIGNATURE

G. H. Richards M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED

11-23-166

22a. PHYSICIAN'S
NAME (Type)

G. H. Richards M.D.

22d. ADDRESS

Port Deposit, Maryland

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

11-27-1966

23c. NAME OF CEMETERY OR CREMATORI

St. Mary Anns Cemetery

23d. LOCATION (City, town or county)

Nort East, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Lee A. Patterson & Son, Perryville, Md.

ADDRESS

25a. REC'D BY REGISTRAR

Charles Judge

DATE DEC 1 1966

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15526

CERTIFICATE OF DEATH

15527

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

| | | | | | | | | |
|---|---------------------------------|--|--|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | b. COUNTY Cecil | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit | | d. STREET ADDRESS 07.1 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Craigtown Road | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Sara | | First | Middle E. | Lost | 4. DATE OF DEATH Mitchell | Month Nov | Doy 27 | Year 1966 |
| 5. SEX Female | 6. COLOR OR RACE Cau. | 7. MARRIED WIDOWED <input checked="" type="checkbox"/> | NEVER MARRIED DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 15, 1872 | 9. AGE (In years lost birthday) 94 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. DAYS 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Samuel Colgain | | 14. MOTHER'S MAIDEN NAME Esther Sparks | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 215-54-2715 | | |
| 17. INFORMANT Mrs. Elsie Bailey, Port Deposit, Md. | | Address | | 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 331X Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last: (b) Generalized Atherosclerosis (c) Old age | | 19. INTERVAL BETWEEN ONSET AND DEATH 2 yrs | | |
| 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from June 1955 to Nov 27, 1966 , that (I) (we) last saw the deceased alive on Nov 15 1966 , and that death occurred at M , from causes and on the date stated above. | | 22b. DATE SIGNED 11/28/66 | | 22c. SIGNATURE Dudley Phillips | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) Dudley Phillips MD | | 22d. ADDRESS Dillington 2nd | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11-30-1966 | 23c. NAME OF CEMETERY OR CREMATORIAL Greensboro Cemetery | 23d. LOCATION (City or Town) (County) (State) Greensboro, Md. |
| 24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md. | | ADDRESS | | 25a. RECEIVED BY REGISTRAR Charles Judge | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |
| VR A15 (4) 20 M 1/66 | | DATE DEC 1 1966 | | 25a. RECEIVED BY REGISTRAR Charles Judge | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

1920

1921

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15527

CERTIFICATE OF DEATH

15528

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|--------------------------|--|---------------------------|---|--|---|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville | | c. LENGTH OF STAY IN lb 2 months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington | | 46. 3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frenchtown Road | | d. STREET ADDRESS 1915 Marsh Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Edith | | First | Middle M. | Last Moore | 4. DATE OF DEATH November | Month 27 | Day 1966 |
| S. SEX Female | 6. COLOR OR RACE Cau. | 7. MARRIED WIDOWED | NEVER MARRIED DIVORCED | B. DATE OF BIRTH 9/26/1901 | 9. AGE (In years last birthday) 65 | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Delaware Hospital | | 11. BIRTHPLACE (County & State, or foreign country) Penns. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Samuel Marshall | | 14. MOTHER'S MAIDEN NAME Winifred Robinson | | Address | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 021-14-9945 | | 17. INFORMANT Mrs. Betty Thompson, Perryville, Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 3 hours | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8-13, 1966, to 11-27, 1966, that (I) (we) last saw the deceased alive on 11-25, 1966, and that death occurred at 44 M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE G. H. Richards | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 11-28-66 | | | |
| 22c. PHYSICIAN'S NAME (Type) G. H. Richards, Jr. | | 22d. ADDRESS Port Deposit, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov. 29, 1966 | | 23c. NAME OF CEMETERY OR CREMATORIAL Asbury Cem. | | 23d. LOCATION (City or Town) (County) (State) Port Deposit, Cecil, Md. | |
| 24. FUNERAL DIRECTOR See J. Patterson & Son | | ADDRESS Perryville, Md. | | 25a. REC'D BY REGISTRAR DATE DEC 1 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

ABSTRACT

1923A

1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15528

CERTIFICATE OF DEATH

15529

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | |
|--|-------|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Cecil. | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton 07-1 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | | |
| 3. NAME OF DECEASED (Type or print) WILLIAM | | First T. | Middle PARKS. | |
| 4. DATE OF DEATH November 27, 1966 | Month | Day | Year | |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming. | | |
| 13. FATHER'S NAME William G. Parks. | | 14. MOTHER'S MAIDEN NAME Della Durell | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT George Parks, Address Chesapeake City, Md. R.D. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.1 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Prob. coronary occlusion and massive infarction 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cecilton, Md. 21913 | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1966 to 27 Nov, 1966 that (I) (we) last saw the deceased alive on 27 Nov 1966 , and that death occurred at 6 a.m. M. from the causes and on the date stated above. | | | | 22b. DATE SIGNED 29 Nov 66 |
| 22a. SIGNATURE <i>Wallace Obenshain</i> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | |
| 22c. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D. | | 22d. ADDRESS Cecilton, Md. 21913 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov. 29, 1966 | | 23c. NAME OF CEMETERY OR CREMATORIAL Johnstown Cemetery |
| 24. FUNERAL DIRECTOR Edward Fellows, | | ADDRESS Millington, Md. | | 23d. LOCATION (City, town or county) (State) Earleville, Cecil Co; Md. |
| 25a. REC'D BY REGISTRAR DEC 2 1966 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15530

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First ALMA | Middle E. | Last PEARCE |
| 4. DATE OF DEATH November 28, 1966 | Month | Day | Year |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 23, 1889 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 9. AGE (In years last birthday) 76 yrs. |
| 13. FATHER'S NAME Joshua Reed. | | 11. BIRTHPLACE (County & State, or foreign country) Md. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Andrew Jackson Pearce, Cecilton, Md. 21913 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atrophy of right leg due to embolus of femoral artery | | | |
| 20a. ACCIDENT WAS UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 19 | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1 Aug 1966 , to 28 Nov 1966 , that (I) (we) last saw the deceased alive on 298 Nov 1966 and that death occurred at 10:00 P.M. causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Wallace Obenshain</i> | 22b. DATE SIGNED 1 Dec 66 | | |
| 22c. PHYSICIAN'S NAME (Type) Wallace Obenshain. M.D. | 22d. ADDRESS Cecilton, Md. 21913 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec. 2, 1966 | 23c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery | 23d. LOCATION (City, town or county) Chesapeake City, Md. |
| 24. FUNERAL DIRECTOR Edward Fellows. | | ADDRESS Millington, Md. | 25a. REC'D BY REGISTRAR DATE DEC 5 1966 |
| | | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

15530

CERTIFICATE OF DEATH

15531

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| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. LENGTH OF STAY IN 1b 51 days Darlington | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital | | d. STREET ADDRESS RD 1 Box 113 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Clayton Middle D. PFRAFF | | 4. DATE OF DEATH Month November Day 9 Year 1966 | |
| 5. SEX Male White | | 6. COLOR OR RACE 7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-Retired | | 8. DATE OF BIRTH 12 3 90 | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years lost birthday) 75 yrs. | |
| 11. BIRTHPLACE (County & State, or foreign country) Frostburg, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Conrad Pfaff (Deceased) | | 14. MOTHER'S MAIDEN NAME Jennie Doring (Deceased) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I | | 16. SOCIAL SECURITY NO. 220-10-21-02 | |
| 17. INFORMANT VA Hospital Records - Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchogenic carcinoma of both lungs</u> | | 6 months | |
| DUE TO | | | |
| DUE TO | | | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <u>IRINA REUS</u> (this hospital) attended the deceased from <u>9-19-66</u> , 19 <u>1966</u> , to <u>11-9-66</u> , 19 <u>1966</u> , and that death occurred at <u>4pm</u> M, from causes and on the date stated above. | | 22b. DATE SIGNED 11 10 66 | |
| 22c. PHYSICIAN'S NAME (Type) IRINA REUS, M.D. | | 22d. ADDRESS VAH PERRY POINT, MD. | |
| 23a. BURIAL CREMATION REMOVAL REMOVAL | | 23b. DATE THEREOF 11 10 66 | |
| 23c. NAME OF CEMETERY OR CREMATORIAL Skeet Creek Cemetery | | 23d. LOCATION (City or Town) Darlington, Maryland | |
| 24. FUNERAL DIRECTOR PATTISON FUNERAL HOME - Perryville, Md. | | ADDRESS | |
| | | 25. REC'D BY REGISTRAR DATE NOV 15 1966 | |
| | | 26. REGISTRAR'S SIGNATURE Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15531

CERTIFICATE OF DEATH

15532

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

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|--|----------------------------------|--|---|--|--|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Illinois | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chicago | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | d. STREET ADDRESS 504 N. Hamlin Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First CARL | Middle J. | Last POORE | 4. DATE OF DEATH November 16 1966 | Month | Day | Year |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED WIDOWED <input type="checkbox"/> | NEVER MARRIED DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 4-22-08 | 9. AGE (In years last birthday) 58 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. DAYS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Kingsport, Tennessee | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Albert Poore (D) | | | | 14. MOTHER'S MAIDEN NAME Mattie Kane (D) | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW II | | 17. INFORMANT VA Hospital Records, Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia INTERVAL BETWEEN ONSET AND DEATH 5271 | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Chronic pulmonary emphysema, severe 3-4 years stating the underlying cause (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Arteriosclerotic Heart Disease | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from January 7, 1966 , to November 16, 1966 , and that death occurred at 9:15 AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE S. Goldgraben | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D. | | 22d. ADDRESS VA Hospital, Perry Point, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE THEREOF 11-17-1966 | | 23c. NAME OF CEMETERY OR CREMATORIAL Gilpin Manor Mem. Park | | 23d. LOCATION (City or Town) (County) (State) Elkton, Maryland | |
| 24. FUNERAL DIRECTOR See Palman & Son Perryville, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR NOV 21 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15532

CERTIFICATE OF DEATH

15533

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|---------------------------|---|---|---|--|---|--------------------------|-------|
| 1. PLACE OF DEATH a. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | b. COUNTY Harford | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville | | c. LENGTH OF STAY IN lb 17 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital, Perry Point, Md. | | d. STREET ADDRESS Box 14 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) George | | First | Middle D. | Last Price | 4. DATE OF DEATH November 20 1966 | Month | Day | Year |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED WIDOWED | NEVER MARRIED DIVORCED | 8. DATE OF BIRTH 12-29-90 | 9. AGE (In years last birthday) 75 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. Building | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Henry Price | | 14. MOTHER'S MAIDEN NAME Laura Reese | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. WWI | | 17. INFORMANT VA Hospital Rec ords, Perry Point, Md. | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1409 | | Carcinoma of the lip with metastases | | | | INTERVAL BETWEEN ONSET AND DEATH 6 yrs | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause lost. | | (b) Pneumonia | | | | 2 weeks | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 VA | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that (1) <input checked="" type="checkbox"/> hospital attended the deceased from <u>11/3/</u> , 1966, to <u>11/20/</u> , 1966, <input checked="" type="checkbox"/> for causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE <i>S. Goldgraben</i> | | M.D. ATTENDING PHYS. <input type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input checked="" type="checkbox"/> | 22b. DATE SIGNED 11-20-66 | | |
| 22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D. | | 22d. ADDRESS VA Hospital, Perry Point, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov. 23, 1966 | 23c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial Cemetery | 23d. LOCATION (City or Town) Abingdon | | (County) Harford | (State) Md | |
| 24. FUNERAL DIRECTOR McComas Funeral Home, Abingdon, Md. | | ADDRESS | | 25a. RECD BY REGISTRAR NOV 22 1966 | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | DATE | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15533

CERTIFICATE OF DEATH

15534

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|--|----------------------------------|---|--|--|---|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | | | c. LENGTH OF Stay w/b 5 days 4 yrs 9 mos | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | | | d. STREET ADDRESS Hillcrest Heights | | | |
| 3. NAME OF DECEASED (Type or print) | | First PAUL | Middle | Last SAN LUIS | 4. DATE OF DEATH November | Month 8 | Day Year 1966 |
| S. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> | NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 6-27-09 | 9. AGE (In years last birthday) 57 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired navy steward | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Phillipine Islands | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Poncians San Luis (D) | | | | 14. MOTHER'S MAIDEN NAME Victoria (Unk) (D) | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) PL 28 | | 16. SOCIAL SECURITY NO. 3-9-27-1-21-51 | | 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) DUE TO (c) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 7, 1962 to November 8, 1966 and that death occurred at 7:50 P.M. from causes and on the date stated above in Part II. | | | | | | | |
| 22a. SIGNATURE Balbir Singh, M.D. | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) BALBIR SINGH, M.D. | | | | 22d. ADDRESS VAH, Perry Point, Md. | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Perry Point | | 23b. DATE THEREOF 11/15/1966 | | 23c. NAME OF CEMETERY OR CREMATORIAL Arlington National | | 23d. LOCATION (City or Town) Ft. Meyer, Virginia (County) (State) | |
| 24. FUNERAL DIRECTOR Patterson Funeral Home, Perryville, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR NOV 15 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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PROBLEMS IDENTIFIED

RECOMMENDATIONS

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GENERAL INFORMATION

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15535

15534

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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|---|----------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. LENGTH OF STAY IN 1b 83 days | | d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | d. STREET ADDRESS 2819 14th St., N.W. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) LAURENCE ALEXANDER SAVOY | | First | Middle | Lost | 4. DATE OF DEATH Month November 14 1966 |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED WIDOWED <input checked="" type="checkbox"/> | NEVER MARRIED DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-15-12 | 9. AGE (In years last birthday) 54 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Washington, DC | |
| 13. FATHER'S NAME Daniel Savoy (D) | | 14. MOTHER'S MAIDEN NAME Catherine (?) (D) | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMEO FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II | | 16. SOCIAL SECURITY NO. 579-05-5268 | | 17. INFORMANT Address VA Hospital Records, Perry Point, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO last. (c) | | Broncho-pneumonia bilateral severe | | INTERVAL BETWEEN ONSET AND DEATH 10-14 days | |
| Carcinoma of Esophagus | | | | 5-10 Months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) August 23, 1966 | (County) (State) |
| 21. I certify that JOEL BLANCAFLOR (this hospital) attended the deceased from August 23, 1966 to November 14, 1966 , and that death occurred at 1:30 P.M. from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE JOEL BLANCAFLOR | | pm | | 22b. DATE SIGNED 11-15-66 | |
| 22c. PHYSICIAN'S NAME (Type) JOEL BLANCAFLOR, M.D. | | 22d. ADDRESS VAH, Perry Point, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE THEREOF 11/18/66 | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Permitton National Cemetery | 23d. LOCATION (City or Town) Washington | (County) (State) D.C. |
| 24. FUNERAL DIRECTOR Charles Bullock | | ADDRESS Bullock Funeral Home, Havre de Grace, Md. | | 25a. REC'D. BY REGISTRAR NOV 21 1966 | 25b. REGISTRAR'S SIGNATURE Charles Judge |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15536

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> | | c. LENGTH OF STAY IN 1b <u>6 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u> | | d. STREET ADDRESS <u>Rt. 7</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>LAURENCE</u> | | First <u>LAURENCE</u> | Middle <u>MILLER SIMMONS</u> |
| 4. DATE OF DEATH Month <u>November</u> | Month <u>29</u> | Day <u>19</u> | Year <u>66</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 5, 1913</u> |
| 9. AGE (In years last birthday) <u>53</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proof Technician</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>Cecil Co. Maryland</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>John Simmons</u> | 14. MOTHER'S MAIDEN NAME <u>Mary Dicks</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | 16. SOCIAL SECURITY NO. <u>WW 2 218-03-0593</u> | 17. INFORMANT <u>Mrs. Elizabeth E. Simmons</u> | Address <u>North East, Md.</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent Coronary Occlusion with Myocardial Infarction</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | |
| 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> (c) <u>—</u> | | 17 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> |
| 20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>28 Dec 1965</u> to <u>29 Nov 1966</u> , that (I) (we) last saw the deceased alive on <u>29 Nov 1966</u> , and that death occurred at <u>5:54 A.M.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Klaus H. Huebner</u> | | 22b. DATE SIGNED <u>11/29/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Klaus H. Huebner</u> | | 22d. ADDRESS <u>Cecil Ave. North East, Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>12/2/66</u> | 23c. NAME OF CEMETERY OR CREMATORIAL <u>Immaculate Conception</u> |
| 23d. LOCATION (City or Town) <u>Cherry Hill</u> | | (County) <u>Cecil</u> | (State) <u>Md.</u> |
| 24. FUNERAL DIRECTOR Grant Funeral Home <u>Paul P. Brouche</u> | | ADDRESS <u>Box 22 North East, Md.</u> | 25a. REC'D BY REGISTRAR <u>DEC 2 1966</u> |
| | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15536

CERTIFICATE OF DEATH

15537

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville | | c. LENGTH OF STAY IN lb | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Richmond Hill Apt. | | d. STREET ADDRESS Richmond Hill Apt. | |
| 3. NAME OF DECEASED (Type or print) Elmore | | First G. | Middle Smith |
| 4. DATE OF DEATH November 20, 1966 | Month | Day | Year |
| 5. SEX Male | 6. COLOR OR RACE Can. | 7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> | 8. DATE OF BIRTH 6-30-1883 |
| 9. AGE (In years lost birthday) 83 yrs. | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days | 12. IF UNDER 24 HRS. Hours |
| 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Samuel G. Smith | | 14. MOTHER'S MAIDEN NAME Emma E. Morgan | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 148-03-9174 | |
| 17. INFORMANT Mrs. Ada Smith, Perryville, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 293X DUE TO <i>old age</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1964 to 1966 that (I) (we) last saw the deceased alive on 19 , and that death occurred at M , from causes and on the date stated above. | | | |
| 22a. SIGNATURE John D. Yon | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED |
| 22c. PHYSICIAN'S NAME (Type) JOHN D. YON | | 22d. ADDRESS House de Grace, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11-23-66 | 23c. NAME OF CEMETERY OR CREMATORIAL Asbury Cemetery |
| 24. FUNERAL DIRECTOR Lee A. Patterson & Sons, Perryville, Md. | | 23d. LOCATION (City or Town) Port Deposit, Md. | (County) (State) |
| | | 25a. ADDRESS Lee A. Patterson & Sons, Perryville, Md. | 25b. REGISTRAR'S SIGNATURE Charles Judge |
| | | 25c. DATE NOV 28 1966 | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15538

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician, then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial.

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| 1. PLACE OF DEATH e. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland | | b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. LENGTH OF STAY IN 1b 2 wks | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital | | | | d. STREET ADDRESS 229 Hollingsworth Manor | | d. STREET ADDRESS 229 Hollingsworth Manor | |

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|--|--|-------|--------|------|----------------------------------|-------|-----|------|
| 3. NAME OF DECEASED (Type or print) KATHLEEN | | First | Middle | Last | 4. DATE OF DEATH Nov. 4, 1966 | Month | Day | Year |
|--|--|-------|--------|------|----------------------------------|-------|-----|------|

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| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH Jan. 28, 1934 | | 9. AGE (In years last birthday) 32 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Line Operator | | 10b. KIND OF BUSINESS OR INDUSTRY R.M.R. Corp. | 11. BIRTHPLACE (County & State, or foreign country) Virginia | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
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| 13. FATHER'S NAME Benjamin Justus | | 14. MOTHER'S MAIDEN NAME Eliza Smith | | Address | | | |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO | | 16. SOCIAL SECURITY NO. 220-44-3577 | 17. INFORMANT Vernon Smith, Elkton, Md. | Address | | | |
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| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH 1-2 HOURS | | | |
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| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA | | DUE TO RADIATION PERITONITIS | | | |
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| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) | | DUE TO RADIATION PERITONITIS | | | |
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| } (c) CANCER OF CERVIX | | DUE TO RADIATION PERITONITIS | | | |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
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|---|--|--|--|--|--|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | |
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| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) | (State) |
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| 21. I certify that (I) (this hospital) attended the deceased from..... 11/21, 1966 to..... 11/3, 1966 that (I) (we) last saw the deceased alive on..... 11/2, 1966, and that death occurred at 11:15 A.M. from the causes and on the date stated above. | | 22b. DATE SIGNED 11/7/66 | | | |
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| 22e. SIGNATURE J. R. Ross | | 22b. DATE SIGNED 11/7/66 | | | |
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| 22c. PHYSICIAN'S NAME (Type) J. R. Ross M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
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| 23e. BURIAL, CREMATION, REMOVAL. (Specify) BURIAL | | 23b. DATE THEREOF 11/7/66 | | | |
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|---|--|---|--|--|--|
| 23c. NAME OF CEMETERY OR CREMATORIAL GILPIN MANOR MEMORIAL PARK, ELKTON, MD. | | 23d. LOCATION (City, town or county) (State) | | | |
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| 24 FUNERAL DIRECTOR'S SIGNATURE Hicks Home for Funerals, Elkton, Md. | | 25a. REC'D BY REGISTRAR NOV 18 1966 | | | |
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| ADDRESS | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |
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1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15538

CERTIFICATE OF DEATH

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| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b 22 Years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton 07-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital Of Cecil County | | d. STREET ADDRESS 109 Milburn St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Bessie | | First Sparks | Middle Sparks 4. DATE OF DEATH Month 11 Day 10 Year 1966 |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/13/95 9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 13. FATHER'S NAME Arthur John Rochester | | 11. BIRTHPLACE (County & State, or foreign country) Goldsboro, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address Mrs. Mildred Wilson, Chestertown, Md. |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Of Gastro-Intestinal Tract. INTERVAL BETWEEN ONSET AND DEATH 7 mos. | | | |
| 159X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO (b) DUE TO (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that (I) attended attended the deceased from May 12, 1966 , to 11/10/ 1966 , that (I) (we) last saw the deceased alive on 11/10/ 1966 , and that death occurred at 11:15 M , from the causes and on the date stated above. | | A: 22b. DATE SIGNED 11/11/66 | |
| 22a. SIGNATURE James L. Johnson | | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> M.O. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED 11/11/66 |
| 22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D. | | 22d. ADDRESS 245 E. High Street, Elkton, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/14/66 | 23c. NAME OF CEMETERY OR CREMATORIAL Richneck Hall, Cemetery Ewingtown 23d. LOCATION (City, town or county) (State) Md. |
| 24. FUNERAL DIRECTOR Edw. R. Bell | | ADDRESS 909 Poplar St. | 25a. REC'D BY REGISTRAR NOV 17 1966 25b. REGISTRAR'S SIGNATURE Charles Judge |

08201

Brooklyn 10-3000

08202

200-10-3000 200-10-3000

200-10-3000 200-10-3000

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15539

CERTIFICATE OF DEATH

15540

| | | | | | |
|--|----------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Cecil | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville, Maryland | | | c. LENGTH OF STAY IN 16 5 yrs, 1 mo./16 days | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) William Stanich | | First | Middle | Last | 4. DATE OF DEATH Month November 27 1966 |
| S. SEX Male | 6. COLOR OR RACE White | 7. MARRIED WIDOWED <input type="checkbox"/> | NEVER MARRIED DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 1894 | 9. AGE (In years last birthday) 72 yrs. |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner | | 10b. KIND OF BUSINESS OR INDUSTRY mining | | 11. BIRTHPLACE (County & State, or foreign country) Yugoslavia | |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. WW I 217-54-9830 | | 17. INFORMANT VA Hospital Records - Perry Point, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculous Pneumonia INTERVAL BETWEEN ONSET AND DEATH 002.1 -- DUE TO (b) Miliary Tuberculosis of Lungs Advanced 3-6 Mo. DUE TO (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Whole History of Tuberculosis 1952 | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. VA 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) (State) |
| 21. I certify that VA Hospital, Perry Point , attended the deceased from October 11, 1961 , to 11/27, 1966 , VA Hospital, Perry Point , and that death occurred at 3:30 AM , from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Balbi Singh M.D. | | M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED 11 29 66 | | |
| 22c. PHYSICIAN'S NAME (Type) BALBI SINGH, M.D. | | 22d. ADDRESS VA Hospital, Perry Point, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE THEREOF 11 29 66 | 23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National | 23d. LOCATION (City or Town) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR Pennington & Son Funeral Home - Havre de Grace, Md. | | ADDRESS | 25a. REC'D BY REGISTRAR DEC 2 1966 | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

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saline 0.9% 0.25% 0.5% 1.0% 2.0%

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control - control index

removal - control index

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15540

CERTIFICATE OF DEATH

15541

1. PLACE OF DEATH
a. COUNTY

Cecil

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Chesapeake City

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Morgan Nursing Home

3. NAME OF
DECEASED
(Type or print)First
ElsieMiddle
L.S.Last
Taylor4. DATE
OF
DEATH
November 10, 1966

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

 NEVER MARRIED

8. DATE OF BIRTH

June 15, 1893

9. AGE (In years
last birthday)

73

10. IF UNDER 1 YEAR

yrs.

11. IF UNDER 24 HRS.

Months

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife.

10b. KIND OF BUSINESS OR
INDUSTRY

Own Home.

11. BIRTHPLACE (County & State, or foreign country)

Philadelphia, Pa.

13. FATHER'S NAME

Joseph Frazer

14. MOTHER'S MAIDEN NAME

Susan Groves.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No.

16. SOCIAL SECURITY NO.

164-03-8520B

17. INFORMANT

Davis Taylor,

Address

Cecilton, Md. 21913

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Ventricular Fibrillation

INTERVAL BETWEEN
ONSET AND DEATH

10 hrs.

170X DUE TO Cardiac Arrhythmias following

Conditions, If any, which

gave rise to Immediate

cause (a), stating the

underlying cause last.

(b) DUE TO CA of Breast operation

36 days.

(c) Arteriosclerotic Cardiovascular Disease

15 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, notify MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)

20d. INJURY OCCURRED
While at work Not White
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1961, to Nov 1966, that (I) ~~was~~ last
saw the deceased alive on Nov 8 1966, and that death occurred at 1:30M from the causes and on the date stated above.

22a. SIGNATURE

M.D. ATTENDING PHYS. M.D. DIRECTOR STAFF PHYS.

22b. DATE SIGNED

22c. PHYSICIAN'S
NAME (Type)

Walter H. Lee. M.D.

22d. ADDRESS

206 S.Broad St; Middletown, Del.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

Nov. 12, 1966

23c. NAME OF CEMETERY OR CREMATORI

Fernwood Cemetery.

23d. LOCATION (City, town or county) (State)

Landsdowne, Pa.

24. FUNERAL DIRECTOR

Edward Fellows,

ADDRESS

Millington, Md. 21651

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE NOV 14 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

101-00-8209 0001-0000-0000-0000-0000-0000-0000-0000

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15541

CERTIFICATE OF DEATH

15542

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | |
|---|---------------------------|--|---------------------------|---|---|---|--|---------------------------|-----------------------|---------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | b. COUNTY Prince George's | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville | | c. LENGTH OF STAY IN 1b 67 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum | | d. STREET ADDRESS 5709 Chillum Heights Drive | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital, Perry Point, Maryland | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Edward | Middle Joseph | Lost Tenly | 4. DATE OF DEATH November 20 1966 | Month November | Doy 20 | Year 1966 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED WIDOWED | NEVER MARRIED DIVORCED | B. DATE OF BIRTH 9-4-95 | 9. AGE (In years lost birthday) 71 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. DAYS Hours 0 | Min. 0 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver | | 10b. KIND OF BUSINESS OR INDUSTRY Hauling | | 11. BIRTHPLACE (County & State, or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 13. FATHER'S NAME James Tenly | | | | 14. MOTHER'S MAIDEN NAME Alice Eggleston | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. WW I | | 17. INFORMANT VA Hospital Records, Perry Point, Md. | | Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Bronchopneumonia | | | | INTERVAL BETWEEN ONSET AND DEATH 5-10 days | | | | |
| 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO (b) Congestive heart failure | | | | -- | | | | |
| | | DUE TO (c) Arteriosclerotic heart disease | | | | -- | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) VA | (County) Baltimore | (State) Maryland |
| 21. I certify that (I, the physician) attended the deceased from 9-14-1966, to 11-20-1966, and that death occurred at 5:15 p.m. XXXXXX , and that death occurred at 5:15 p.m., from causes and on the date stated above. | | 22b. DATE SIGNED 11-21-66 | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D. | | 22d. ADDRESS VAH, Perry Point, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 11/23/1966 | | 23b. DATE THEREOF 11/23/1966 | | 23c. NAME OF CEMETERY OR CREMATORIUM Arlington National | | 23d. LOCATION (City or Town) Arlington | | | | |
| 24. FUNERAL DIRECTOR Takoma Park Funeral Home, 254 Carroll St., N.W. | | ADDRESS Wash. DC | | 25a. REC'D BY REGISTRAR NOV 23 1966 | | 25b. REGISTRAR'S SIGNATURE J Charles Judge | | | | |

SP-61

1. *Emulsion*
2. *Emulsion*
3. *Emulsion*

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15542

CERTIFICATE OF DEATH

15543

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | |
|--|---------------------------|--|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. LENGTH OF STAY IN 1b 33 Years | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital Of Cecil County | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D.# 3, Elkton, Md. 071 | | |
| d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | First John | Middle Henry | 4. DATE OF DEATH Month 11 Doy 28 Year 1966 | |
| S. SEX Male | 6. COLOR OR RACE White | 7. MARRIED WIDOWED <input checked="" type="checkbox"/> | NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 6/3/89 | | 9. AGE (In years 77 at birthday) yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY Elk Paper Co. | | |
| 11. BIRTHPLACE (County & State, or foreign country) Hay Springs, Nebraska | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Andrew Van Den Heuvel | | 14. MOTHER'S MAIDEN NAME | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-05-3898 Mrs. Marcella Dalgarn Same | | |
| 17. INFORMANT Address | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 334X DUE TO Arterio- Sclerotic Cerebro Vascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Heart Disease (c) DUE TO 2- Years | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 10/28/1966 to 11/28/1966 that (I) (we) last saw the deceased alive on 10/28/1966, and that death occurred at 2:30 P.M. from causes and on the date stated above. | | 22b. DATE SIGNED 11/29/66 | | |
| 22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D. | | 22d. ADDRESS 245 E. High St., Elkton, Maryland | 23d. LOCATION (City or Town) (County) (State) Cherry Hill, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/1/66 | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Immaculate Conception | |
| 24. FUNERAL DIRECTOR Hicks Home for Funerals, Elkton, Md. | | 25a. REC'D BY REGISTRAR DEC 7 1966 | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

1223

1222

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15543

CERTIFICATE OF DEATH

15544

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | |
|--|--|--|-----------------------|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | b. COUNTY Harford | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge | | c. LENGTH OF STAY IN lb 1 hr. 48 min. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen | | d. STREET ADDRESS Apartment D 9-1 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Station Hospital, U: SNTC | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Shawn Allen VOLK | | First | Middle | Lost | 4. DATE OF DEATH November 6 1966 | Month | Day Year | |
| 5. SEX Male Caucasian | | 6. COLOR OR RACE Caucasian | 7. MARRIED WIDOWED | NEVER MARRIED DIVORCED | 8. DATE OF BIRTH November 6, 1966 | | 9. AGE (In years lost birthday) yrs. 1 48 | 10. IF UNDER 1 YEAR Months Doy Hours 1 48 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----- | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (County & State, or foreign country) Cecil County, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Albert Leroy VOLK | | | | 14. MOTHER'S MAIDEN NAME Brenda Kay HUDSON | | Address | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ----- | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Hospital Records | | 18. INTERVAL BETWEEN ONSET AND DEATH | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7547 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | DUE TO Congenital Heart Failure | | DUE TO Congenital Heart Disease | | DUE TO Transposition of Great vessels + Large VSD. | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 6 November 1966, to 6 Nov. 1966 that <input type="checkbox"/> <input checked="" type="checkbox"/> last saw the deceased alive on 6 November 1966, and that death occurred at 9:25 M, from causes and on the date stated above. | | 22b. DATE SIGNED 11/7/66 | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) SOL ROCKENMACHER LT MC USNR | | M.D. ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22d. ADDRESS Bainbridge, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 9 November 1966 | | 23c. NAME OF CEMETERY OR CREMATORIUM Nottingham Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colora Cecil Md. | | |
| 24. FUNERAL DIRECTOR LEE A. PATTERSON & SON, PERRYVILLE, MD | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE NOV 15 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

1621

2223

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15544

15545

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Cecil | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | b. COUNTY Cecil | |
| c. LENGTH OF STAY IN b. 1 mo. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital | | d. STREET ADDRESS R.D. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First Mary | Middle Miller | Last Williams |
| 4. DATE OF DEATH | Month Nov. | Day 26 | Year 1966 |
| 5. SEX | 6. COLOR OR RACE Female | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Apr. 9, 1909 |
| 9. AGE (In years last birthday) 57 yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fortune Teller | 11. KIND OF BUSINESS OR INDUSTRY -- | 12. BIRTHPLACE (County & State, or foreign country) Illinois |
| 13. FATHER'S NAME Uaigh Miller | 14. MOTHER'S MAIDEN NAME Bolinka Miller | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Louis Williams, Elkton, Md. | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. } (b) CARDO-RESPIRATORY FAILURE DUE TO (c) CANCER OF THE LUNGS | | INTERVAL BETWEEN ONSET AND DEATH 4 mts. 8-10 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from FEB. 1966, to NOV. 26, 1966, that (I) (we) last saw the deceased alive on NOV. 25, 1966, and that death occurred at M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Rolando A. Najera, M.D. | 22b. ATTENDING PHYS. <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> |
| 22c. PHYSICIAN'S NAME (Type) Rolando A. Najera, M.D. | 22d. ADDRESS 105 East Main Street, Elkton, Md. | 22b. DATE SIGNED 11/26/66 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 11/29/66 | 23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Cemetery | 23d. LOCATION (City, town or county) Elizabeth, N.J. (State) |
| 24 FUNERAL DIRECTOR'S SIGNATURE Hicks Home for Funerals, Elkton, Md. | ADDRESS | 25a. REC'D BY REGISTRAR Charles Judge | 25b. REGISTRAR'S SIGNATURE Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15545

CERTIFICATE OF DEATH

15546

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY CECIL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md. | | c. LENGTH OF STAY IN 1b 61 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Abraham | | First Abraham | Middle WISE |
| 4. DATE OF DEATH November 9 1966 | Month Day Year | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12 2 89 |
| 9. AGE (In years last birthday) 76 yrs. | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS. Days 0 | 12. IF UNDER 24 HRS. Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Abraham (Deceased) | | 14. MOTHER'S MAIDEN NAME Emma Crozier (Deceased) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.I | | 16. SOCIAL SECURITY NO. 212-18-29-70 | |
| 17. INFORMANT VA Hospital Records - Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia with pulmonary edema | | INTERVAL BETWEEN ONSET AND DEATH 5-6 days | |
| 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure (c) Arteriosclerotic heart disease | | years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of prostate | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA Hospital - Perry Point, Md. |
| 21. I certify that (b) (this hospital) attended the deceased from 4 22 66 , 19, to 11 9 66 , 19, the 11 10 66 , 19, and that death occurred at 5:45 P.M. from causes and on the date stated above. | | 22b. DATE SIGNED 11 10 66 | |
| 22a. SIGNATURE Balbir Singh M.D. | | M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22d. ADDRESS VA Hospital - Perry Point, Md. |
| 22c. PHYSICIAN'S NAME (Type) BALBIR SINGH, M.D. | | 23d. LOCATION (City or Town) Baltimore Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE THEREOF 11 10 66 | 23c. NAME OF CEMETERY OR CREMATORIUM Baltimore National |
| 24. FUNERAL DIRECTOR FRANKLIN W. SEITZ 814 W 36th St Balt Md. | | ADDRESS | 25a. REC'D BY REGISTRAR NOV 15 1966 |
| | | | 25b. REGISTRAR'S SIGNATURE Charles Judge |

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